

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-034481
STATE FILE NUMBER
9059
Registrar's No.

FILED OCT 3 1958 Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY <i>None</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo.</i> b. COUNTY <i>None</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St. Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>St. Louis</i>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>St. Louis Chronic</i>		Length of stay in lb <i>6 1/2 yrs.</i>	d. STREET ADDRESS (If outside, give location) <i>1954 N. Kingshighway</i>
3. NAME OF DECEASED (Type or print) First <i>Bertram</i> Middle <i>J</i> Last <i>McKenzie</i> <i>Bert McKenzie</i>		4. DATE OF DEATH Month <i>9</i> Day <i>18</i> Year <i>1958</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/20/1884</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waiter (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Noonday Club</i>	11. BIRTHPLACE (City and state or country) <i>Chicago, Ill.</i>
13a. FATHER'S NAME <i>James McKenzie</i>		13b. MOTHER'S MAIDEN NAME <i>Mary Russell</i>	14. NAME OF HUSBAND OR WIFE <i>Clara</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>XX</i>		16. SOCIAL SECURITY NO. <i>488-10-0384</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Recurrent Left Middle Cerebral Art. Thrombosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 yrs. & 3 days</i>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <i>Cerebral arteriosclerosis</i>		<i>7 yrs.</i>	
DUE TO (c) <i>Generalized Arteriosclerosis 332x</i>		<i>7 yrs.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <i>Aphasia and Right Hemiplegia - 7 yrs.</i>		18. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20e. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <i>2/7/52</i> to <i>9/18/58</i> and last saw him alive on <i>9/18/58</i> Death occurred at <i>6:55 P.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>John W. Beckham, M.D.</i>		22b. ADDRESS <i>5800 Arsenal</i>	22c. DATE SIGNED <i>9/19/58</i>
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>	23b. DATE! <i>Sept 20 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>New Bethlehem Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Missouri</i>
24. FUNERAL DIRECTOR <i>Math Hermann & Son, Inc., 2161 E. Fair</i>		25. DATE RECD. BY LOCAL REG. <i>SEP 19 1958</i>	26. REGISTRAR'S SIGNATURE <i>J. Carl Smith MO</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Allen W. Hay*

Licensed Embalmer No. *3737*
P. O. Address *St. Louis Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.